



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

September 9, 2010

Steve Silberberger, Administrator
Seven Oaks Community Homes - Cleveland
3940 West 5th Avenue #c
Post Falls, ID 83854

RE: Seven Oaks Community Homes - Cleveland, Provider #13G049

Dear Mr. Silberberger:

This is to advise you of the findings of the Medicaid/Licensure survey of Seven Oaks Community Homes - Cleveland, which was conducted on September 2, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
3. Identify the date each deficiency has been, or will be, corrected.
4. Sign and date the form(s) in the space provided at the bottom of the first page.
5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of

Steve Silberberger, Administrator
September 9, 2010
Page 2 of 2

being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **September 22, 2010**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by September 22, 2010. If a request for informal dispute resolution is received after September 22, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



Jim Troutfetter
Health Facility Surveyor
Non-Long Term Care



Nicole Wisenör
Co-Supervisor
Non-Long Term Care

JT/srp
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2010
NAME OF PROVIDER OR SUPPLIER SEVEN OAKS COMMUNITY HOMES - CLEVELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3732 NORTH CLEVELAND STREET POST FALLS, ID 83854		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Jim Troutfetter, QMRP, Team Leader Barbara Dern, QMRP Common abbreviations/symbols used in this report are: BID - Twice Daily IPP - Individual Program Plan PICA - Eating Non-Edible Items QMRP - Qualified Mental Retardation Professional	W 000	<div style="text-align: center; font-size: 2em; transform: rotate(-15deg); opacity: 0.5;"> RECEIVED OCT 04 2010 FACILITY STANDARDS </div>		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure the use of a behavior modifying drug was used only with the approval of the facility's Human Rights Committee (HRC) for 1 of 3 individuals (Individual #1) whose consents were reviewed. This resulted in an individual receiving a behavior modifying drug without prior approval from HRC. The findings include: Individual #1's IPP documented a 35 year old male diagnosed with profound mental retardation, pica, and obsessive compulsive disorder.	W 262			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Paula Pickett

Program Director

9-30-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 262	Continued From page 1 Individual #1's record contained a Physician's Order, dated 6/1/10, documenting he received Lamictal (an anticonvulsant drug) 25mg BID. Additionally, during a medication pass on 8/31/10, from 7:15 - 7:31 a.m., Individual #1 was observed to receive 25 mg of Lamictal. However, his record did not document HRC approval. When asked during an interview on 9/2/10 at 9:15 a.m., the QMRP stated the HRC did not review the use of Lamictal for Individual #1 and it was an oversight.	W 262			
W 263	The facility failed to ensure HRC reviewed the use of Lamictal for Individual #1 prior to use. 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the use of a behavior modifying drug was used only with the approval of the individual's parent/guardian for 1 of 3 individuals (Individual #1) whose consents were reviewed. This resulted in an individual receiving a behavior modifying drug without prior approval from his parent. The findings include: Individual #1's IPP documented a 35 year old male diagnosed with profound mental retardation, pica, and obsessive compulsive disorder.	W 263	W263 As noted in W262 above it is the facilities practice is to review all medications used to assist individuals to manage their behavior on an annual basis. This review is completed by the QMRP creating a list of medications being used for each person in the home, which is then independently reviewed by the QMRP, the Home Supervisor, and by a member of the nursing staff to ensure that it is complete and accurate. The facility will assign a second member of the nursing staff to create a list independent of the QMRP's list, which will then be reviewed by the individuals listed above to insure that all medications being used are accurately identified and subsequently reviewed with the parent or guardian for his/her consent. Completion Date: October 1, 2010 By Whom: QMRP, Home Supervisor, 2 separate members of the Nursing Staff.		

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W 263	<p>Continued From page 2</p> <p>Individual #1's record contained a Physician's Order, dated 6/1/10, documenting he received Lamictal (an anticonvulsant drug) 25mg BID.</p> <p>Additionally, during a medication pass on 8/31/10, from 7:15 - 7:31 a.m., Individual #1 was observed to receive 25 mg of Lamictal. However, his record did not document parental approval.</p> <p>When asked during an interview on 9/2/10 at 9:15 a.m., the QMRP stated Individual #1's parent had not given approval for the use of Lamictal.</p> <p>The facility failed to ensure parental approval was received prior to the use of Lamictal for Individual #1.</p>	W 263			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2010
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MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	MM194 Please refer to W262	
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196	MM196 Please refer to W263	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

5899

IC9F11

TITLE

Program Director

(X6) DATE

9-30-10

If continuation sheet 1 of 1